I.—THE INDICATIONS FOR SURGICAL TREATMENT IN THE DISEASES OF THE STOMACH.

Read at the Discussion on Diseases of the Stomach at the British Medical Meeting in Edinburgh, 1898.

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THE INDICATIONS FOR SURGICAL TREATMENT IN DISEASES OF THE STOMACH.

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1. In all cases of doubt as to tumours or hardness suspected to be in or near the stomach, or in any case where from tension of the recti muscles a satisfactory examination cannot be obtained, let the patient get chloroform or ether, and the condition be thoroughly investigated. It will be a satisfaction in some cases to find no tumour, and in others points will be determined with a view to operative procedure or not.

2. Where improvement under dietetic and medicinal treatment is delayed and doubt remains in the mind of the physician or physician and surgeon after an examination under chloroform, the surgeon should be asked to make an exploratory incision to determine, if possible, the nature of the growth and the operation required, being prepared to do whatever operation is necessary at the same time. Exploratory incision is a serious operation, and, although it is most exceptional for anything to go wrong, still it should not be undertaken as if it were nothing; while I object to unnecessary explorations, I cordially agree with Mr. Treves's remarks in a recent most able paper on the value of such. In many cases, apart from anything tuberculous, the value of a simple exploratory incision into the abdomen is very great.

To illustrate what I say, I may refer to the case of Mrs. A., aged 57, published in *The British Medical Journal* several years ago. She suffered from the symtoms of pyloric obstruction with gradually increasing tumour in the epigastrium, loss of weight, and no improvement from any dietetic or medicinal treatment, and in these circumstances Dr. Sinclair asked me to see her with a view to doing some operation for her relief.

I explored the abdomen by vertical incision, and found a tumour so extensive, so irregular, so hard, and so adherent that I decided that nothing farther could be done, and we were all agreed that we had a malignant tumour to deal with. The patient never vomited again, the tumour entirely disappeared, and she is now, five years since the operation, continuing quite well.

A lady brought to me by Dr. Campbell after six years of persistent dyspepsia, having the pain worst at one fixed point an inch below the lower end of the sternum, was completely relieved by an exploratory incision and the removal of an unobliterated umbilical vein attached by adhesions to the stomach.

A third case sent by Dr. Orr M'Niven, a man, aged 35, had recurrent attacks of obstruction, due apparently to a tumour in the region of the stomach. On exploration the tumour could not be removed, but has since disappeared, and the patient is well.

In addition to doing a great deal of good in inflammatory and tuberculous cases, it is sometimes useful in staying the progress of malignant growths. No one has yet explained why simple incision does so much good, but there is no doubt that a change of government takes place somewhere.

3. Cases in which the physician has no doubt as to what is wrong, but is anxious to delay surgical interference. The simplest of these are cases of dilatation of the stomach from fermentative dyspepsia. If washing out the stomach with antiseptic fluids and using massage is not sufficient, then gastro-enterostomy ought to be performed, or the operation of Professor Porter, of Boston, by which he puts a tuck in the stomach. When the dilatation is due to simple tumour of the pylorus, it may be either removed or gastro-enterostomy performed; if caused by cicatricial contraction at the pylorus, then splitting the pylorus vertically and uniting it transversely is followed by great success. Patients on whom I have operated continue well after five and seven years, which is long enough to test the value of operations. I would strongly urge the need of not delaying until patients are too weak to enjoy the benefits of operation. I was glad to hear Dr. Lauder Brunton strongly recommending gastro-enterostomy in cases of dilated stomach.

4. Possibly in no other disease have such strides been made medically and surgically as in gastric ulcer. Some have been cut out previous to rupture, and soon, I hope, we may be able to diagnose them absolutely when the gastroscope is improved. When a gastric ulcer ruptures, the sooner it is operated on the better for the patient. The symptoms are so distinct that no delay should take place in the physician and surgeon being associated so that operation may be performed, and already a large number of cases have been operated on with gradually increasing success. The extravasation of much fluid into the abdomen so pinches the patient's vitality that, even with operation, until some modification takes place the mortality must be high.

5. In malignant disease at the cardiac end of the stomach with narrowing of the entrance we can often give great relief by using Simon's tubes or by a gastrostomy; and this should not be too long delayed, for it rests the

diseased part and prolongs life. There is no use waiting until the patient is visibly dying, for that only brings discredit on the operation—or rather, perhaps, on the delay. When the pylorus is affected with malignant disease, either the tumour may be removed or gastro-enterostomy performed, according to the state of the patient and the size of the tumour. The relief afforded in these cases is often very great.

I might have referred to many other points and given details of cases, but I hope that the result of this discussion may be that cases of doubt may be earlier considered by the physician and surgeon with a view to operation.